BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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| In the Matter of the Petition to Revoke Probation Against: | ) | |
| ARIEL ELIAHOU ABRAHAMS, M.D. | ) | Case No. 800-2016-023912 |
| Physician's and Surgeon's Certificate No. G 86496 | ) | |
| Respondent | ) | |

## DECISION AND ORDER

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. First Page, Fourth Paragraph, Second Line, Date will be corrected to read "March 24, 2017."

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 21, 2017.

IT IS SO ORDERED May 22, 2017.

MEDICAL BOARD OF CALIFORNIA

By: _____
Jamie Wright, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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| In the Matter of the Petition to Revoke Probation Against:<br><br>ARIEL ELIAHOU ABRAHAMS, M.D., Physician's and Surgeon's Certificate No. G86496,<br><br>Respondent. | Case No. 800-2016-023912<br><br>OAH No. 2016101035 |

# PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on March 24, 2017, in Los Angeles.

Claudia Ramirez, Deputy Attorney General, represented petitioner Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Respondent Ariel Eliahou Abrahams, M.D., appeared and represented himself.

Oral and documentary evidence was received. The record was closed and the matter was submitted on March 24, 2016.

## FACTUAL FINDINGS

*Jurisdiction*

1. Petitioner filed the Petition to Revoke Probation in her official capacity. Respondent timely filed a notice of defense.

2. The Board issued Physician's and Surgeon's Certificate No. G86496 to respondent on May 8, 2002. That certificate is scheduled to expire on January 31, 2018.

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*Procedural Background*

3. In an administrative action entitled, "In the Matter of the Accusation Against Ariel Eliahou Abrahams, M.D.," Case No. 04-2011-218535, the Board issued a Decision, effective March 2, 2016, adopting a Proposed Decision issued by an administrative law judge.[1] Respondent's certificate was revoked, the revocation was stayed, and respondent was placed on probation for five years on various terms and conditions.

4. Relevant to this petition are probationary conditions 2, 3, and 4.

5. Condition 2 requires respondent, within 60 days of the effective date of probation, to "submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation." (Ex. 1.)

6. Condition 3 requires respondent to "enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education (PACE) offered at the University of California–San Diego School of Medicine (program)" within 60 days of the effective date of probation, and to successfully complete the program within six months of enrollment. (Ex. 1.) "If [r]espondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, [r]espondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program has been completed." (*Ibid.*)

7. Condition 4 requires respondent, within 30 days of the effective date of probation, to "submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified." (Ex. 1.) "If [r]espondent fails to obtain the approval of a monitor within 60 calendar days of the effective date of [probation], [r]espondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility." (*Ibid.*) In lieu of a monitor, respondent was permitted, under Condition 4, to participate in a professional enhancement program equivalent to the one offered by PACE.

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[1] The Board struck the administrative law judge's imposition of a 120-day suspension.

*Petitioner's Allegations*

8. In her Petition to Revoke Probation, petitioner states three causes for revocation against respondent for failure to comply with probationary conditions. The causes for revocation are based on allegations that respondent:

a. failed to submit 40 hours of educational programs or courses to the Board for prior approval within 60 days after the effective date of probation, in violation of probationary Condition 2;

b. failed to enroll in and successfully complete a clinical training or educational program equivalent to the PACE program within 60 days of the effective date of probation, in violation of probationary Condition 3; and

c. failed to submit the name and qualifications of a licensed physician and surgeon for prior approval as a practice monitor, or enroll in a physician enhancement program equivalent to the one offered by the PACE program, within 30 days after the effective date of probation, in violation of probationary Condition 4.

*Respondent's Acts Related to the Petition's Allegations*

9. As of April 11, 2016, 30 days after the effective date of probation, respondent had not identified for prior Board approval a practice monitor or enrolled in a physician enhancement program, in violation of probationary Condition 4. As of May 11, 2016, 60 days after the effective date of respondent's probation, respondent had failed to submit 40 hours of educational programs for Board approval and to enroll in and successfully complete a clinical training or education program, in violation of probationary Conditions 2 and 3.

10. On May 12, 2016, respondent notified his probation monitor Dianna Gharibian, Inspector II with the Board's Probation Unit, that he was unable to comply with his probationary conditions and would cease the practice of medicine effective May 14, 2016. By letter dated May 12, 2016, Ms. Gharibian offered respondent the option of surrendering his certificate. By email and letter to Ms. Gharibian dated May 31, 2016, respondent refused to surrender his certificate; he did not provide a reason for his decision.

11. By letter dated June 7, 2016, Ms. Gharibian notified respondent of his continued non-compliance with probationary conditions. On June 30, 2016, based on respondent's violation of Probationary Conditions 3 and 4, the Board issued and served a Cease Practice Order, effective July 3, 2016, prohibiting respondent from engaging in the practice of medicine pending a final decision on this petition.

12. Ms. Gharibian again notified respondent of his continued non-compliance by letter dated November 14, 2016. In a letter dated March 14, 2017, respondent wrote, "Since I am not able to satisfy the terms and conditions of probation, I herein return my wallet and wall certificate to the board." (Ex. 20.)

13. Respondent testified, with no support in the record, that the discipline imposed on his certificate in Case No. 04-2011-218535 was based on false evidence, including the testimony of people who had committed crimes in the hospital in which he practiced. He acknowledged that he had filed a petition for a writ of mandate in the superior court to challenge the license discipline the Board had imposed, and that his petition was denied. Respondent insisted, again with no support in the record, that he did nothing warranting revocation. He argued, without legal basis, that he was being denied due process because he was unable to secure legal representation for this hearing.

## LEGAL CONCLUSIONS

*Burden of Proof*

1. Petitioner has the burden of proving that probation revocation is warranted by a preponderance of the evidence. "While the board is required to prove the allegations in an accusation by clear and convincing evidence, it is only required to prove the allegations in a petition to revoke probation by a preponderance of the evidence." (*Sandarg v. Dental Bd. of California* (2010) 184 Cal.App.4th 1434, 1441; see also Evid. Code, § 115.)

*Applicable Authority*

2. The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.)[2] The Board is responsible for enforcing the disciplinary and criminal provisions of the Medical Practice Act and "suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions." (§ 2004.) After a disciplinary hearing, the Board may revoke a practitioner's license, place the practitioner on probation and require payment of costs of probation monitoring, and take "any other action . . . in relation to discipline as part of an order of probation, as the [B]oard or an administrative law judge may deem proper." (§ 2227.)

*Cause for Revocation of Probation*

3. Cause exists to revoke probation, impose the stayed disciplinary order, and revoke respondent's certificate, in accordance with the Decision in Case No. 04-2-11-218535, based on respondent's failure to timely submit 40 hours of educational programs for Board approval, in violation of probationary Condition 2, as set forth in Factual Findings 3 through 7 and 9 through 13.

4. Cause exists to revoke probation, impose the stayed disciplinary order, and revoke respondent's certificate, in accordance with the Decision in Case No. 04-2-11-218535, based on respondent's failure to enroll in and successfully complete a clinical training or

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[2] Further statutory references are to the Business and Professions Code.

education program, in violation of probationary Condition 3, as set forth in Factual Findings 3 through 7 and 9 through 13.

5. Cause exists to revoke probation, impose the stayed disciplinary order, and revoke respondent's certificate, in accordance with the Decision in Case No. 04-2-11-218535, based on respondent's failure to timely identify for prior Board approval a practice monitor or, alternatively, to enroll in a physician enhancement program, in violation of probationary Condition 4, as set forth in Factual Findings 3 through 7 and 9 through 13.

6. Revoking probation, imposing the stayed disciplinary order, and revoking respondent's certificate is warranted. Respondent's reasons for contesting the petition rather than surrendering his certificate, even though he decided not to practice and to return his wallet and wall certificates to the Board, are unclear and in any event do not support any other result.

## ORDER

The stay of revocation that the Board ordered in its Decision in Case No. 04-2011-218535 is itself revoked and the stayed revocation is revived. Physician's and Surgeon's Certificate No. G86496, issued to respondent Ariel Eliahou Abrahams, M.D., is revoked.

DATED: April 24, 2017

DocuSigned by:
Howard W. Cohen
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HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearing

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
CLAUDIA RAMIREZ
Deputy Attorney General
State Bar No. 205340
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 897-5678
Facsimile: (213) 897-9395
*Attorneys for Complainant*



**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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|---|---|
| In the Matter of the Petition to Revoke Probation Against:<br><br>ARIEL ELIAHOU ABRAHAMS, M.D.<br>P.O. Box 252125<br>Los Angeles, California 90025<br><br>Physician's and Surgeon's Certificate No. G86496,<br><br>Respondent. | Case No. 800-2016-023912<br><br>**PETITION TO REVOKE PROBATION** |

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about May 8, 2002, the Board issued Physician's and Surgeon's Certificate Number G86496 to Ariel Eliahou Abrahams, M.D. ("Respondent"). That Certificate was in effect at all times relevant to the charges brought herein and will expire on January 31, 2018, unless renewed.

PRIOR DISCIPLINARY HISTORY

3. In a disciplinary action entitled "In the Matter of the Accusation Against Ariel

Eliahou Abrahams, M.D.," Case No. 04-2011-218535, the Board, issued a decision, effective March 12, 2016, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's Certificate was placed on probation for a period of five (5) years with certain terms and conditions. A copy of that decision is attached as Exhibit A and is incorporated by reference.

4. On June 30, 2016, the Board issued and served a Cease Practice Order against Respondent, prohibiting him from engaging in the practice of medicine pending a final decision on the instant Petition to Revoke Probation. That Cease Practice Order, which became effective July 3, 2016, was based on Respondent's failure to obey Probationary Condition Nos. 3 (Clinical Training Program) and 4 (Practice Monitoring) of the Board's Decision and Order in Case No. 04-2011-218535.

JURISDICTION

5. This Petition to Revoke Probation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

6. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Comply with Education Course Condition)

7. At all times after the effective date of Respondent's probation, Condition No. 2, Education Course, stated:

> Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational

program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

8. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 2, referenced above. The facts and circumstances regarding this violation are as follows:

A. As of May 11, 2016, which is 60 calendar days after the effective date of Respondent's probation, Respondent has not submitted 40 hours of educational programs or courses to the Board for prior approval.

B. On or about May 12, 2016, Respondent notified his Probation Monitor that he was unable to comply with the terms and conditions of his probation and would cease the practice of medicine, effective May 14, 2016.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Comply with Clinical Training Program Condition)

9. At all times after the effective date of Respondent's probation, Condition No. 3, Clinical Training Program, stated:

Within 60 calendar days of the termination of suspension, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (program). Respondent shall successfully complete the program not later than six months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment

pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program has been completed. If Respondent did not successfully complete the clinical training program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after Respondent successfully completes the clinical training program, Respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semiannual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

10. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 3, referenced above. The facts and circumstances regarding this violation are as follows:

A. As of May 11, 2016, which is 60 calendar days after the effective date of Respondent's probation, Respondent has not enrolled in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program.

B. On or about May 12, 2016, Respondent notified his Probation Monitor that he was unable to comply with the terms and conditions of his probation and would cease the practice of medicine, effective May 14, 2016.

THIRD CAUSE TO REVOKE PROBATION

(Failure to Comply with Practice Monitoring Condition)

11. At all times after the effective date of Respondent's probation, Condition No. 4, Practice Monitoring, stated:

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not

limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the termination of suspension, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent

to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days. After being so notified, Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

12. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 4, referenced above. The facts and circumstances regarding this violation are as follows:

A. As of April 11, 2016, which is 30 calendar days after the effective date of Respondent's probation, Respondent has not submitted the name and qualifications of a licensed physician and surgeon for prior approval as a practice monitor or enrolled in a physician enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine.

B. On or about May 12, 2016, Respondent notified his Probation Monitor that he was

unable to comply with the terms and conditions of his probation and would cease the practice of medicine, effective May 14, 2016.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking the probation that was granted by the Medical Board of California in Case No. 04-2011-218535 and imposing the disciplinary order that was stayed, thereby revoking Physician's and Surgeon's Certificate No. G86496 issued to Respondent Ariel Eliahou Abrahams, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate No. G86496, issued to Respondent Ariel Eliahou Abrahams, M.D.;

3. Revoking, suspending or denying approval of Respondent Ariel Eliahou Abrahams, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

4. Ordering Respondent Ariel Eliahou Abrahams, M.D., if placed on probation, to pay the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: August 24, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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# Exhibit A

**Decision and Order**

**Medical Board of California Case No. 04-2011-218535**

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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|---|---|
| In the Matter of the Accusation Against: | |
| **ARIEL ELIAHOU ABRAHAMS, M.D.** | Case No. 04-2011-218535 |
| Physician's and Surgeon's Certificate No. G 86496 | OAH No. 2014050319 |
| Respondent. | |

## DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California except that, pursuant to the provisions of Section 11517(c)(2)(B) of the Government Code, the proposed Order is revised to strike Condition No. 1 – Actual Suspension. The striking of this condition calling for a 120-day suspension is not inconsistent with the public's interest in light of the five-year period of probation and other terms and conditions in place to provide public protection and rehabilitation of the licensee.

This decision shall become effective on the 2nd day of March, 2016.

IT IS SO ORDERED this 1st day of February, 2016.

JAMIE WRIGHT, JD, CHAIR
PANEL A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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| In the Matter of the Accusation Against:<br><br>ARIEL ELIAHOU ABRAHAMS, M.D.<br><br>Physician's and Surgeon's Certificate No. G 86496,<br><br>Respondent. | Case No. 04-2011-218535<br><br>OAH No. 2014050319 |

# PROPOSED DECISION

This matter came on regularly for hearing on October 19, 20, 21, 26, 27, 28, and 29, 2015, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Claudia Ramirez, Deputy Attorney General, represented Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board).

Ariel Eliahou Abrahams, M.D. (Respondent) was present and represented himself.

Oral and documentary evidence was received. The record was held open until October 30, 2015, for Respondent to submit a written closing argument.[1] The document was timely received and was marked as Respondent's Exhibit H for identification. The record was closed on October 30, 2015, and the matter was submitted for decision.

## PROTECTION OF PERSONALLY IDENTIFIABLE INFORMATION

This case involves Respondent's care and treatment of a single patient. At the outset of the hearing, the Administrative Law Judge granted Complainant's pre-hearing motion for a protective order sealing Exhibits 3 through 14, 16, and 23 in order to maintain the patient's privacy. The court reporter was instructed to use the patient's initials in a transcript in lieu of her name, and witnesses were requested to do the same.

[1] Complainant offered oral closing argument the day before.

Exhibit H, Respondent's Closing Argument, contained one reference to the patient's name. On his own motion, the Administrative Law Judge redacted the name leaving only the patient's initials.

The patient's initials are also used herein in lieu of her name for the same privacy reasons referenced above.

## FACTUAL FINDINGS

*Respondent's Background*

1. On May 8, 2002, the Board issued Physician's and Surgeon's Certificate No. G 86496 to Respondent. The certificate was in full force and effect at all times relevant to the charges brought in this action. It is current and will expire on January 31, 2016, unless renewed. Respondent has no history of license discipline.

2. Respondent is an obstetrician and gynecologist. He received his medical training at the University of Medicine and Dentistry of New Jersey, earning his medical doctorate in 1993. From 1993 to 1996, he served an internship/residency in obstetrics and gynecology at Flushing Hospital Medical Center in Flushing, New York and, from 1996 to 1998, he served an internship/residency in obstetrics and gynecology at Columbus Hospital in Chicago, Illinois. Respondent has been a diplomate of the American Board of Obstetrics and Gynecology since 2003. He also holds a Ph.D. in Pathology. Respondent is presently an office provider only with offices in Paramount and Downey. Currently, he does not have privileges at any hospital.

*C.P.'s Labor and Delivery*

3. In and around November 2008, Respondent was Patient C.P.'s obstetrician. C.P. had given birth twice before, once by vaginal delivery and once by a term cesarean section for breech presentation. Her estimated due date was December 11, 2008. Because of her prior cesarean section, Respondent's delivery plan was another cesarean section, which was to be performed at 39 weeks gestation.

4. At all relevant times, Respondent was aware that the performance of a cesarean section following an earlier cesarean section could involve certain complications such as the presence of adhesions which would have to be lysed before delivery could be accomplished. The lysing of adhesions would add time to the length of the procedure. At all relevant times, Respondent was also aware that a vaginal birth after cesarean (VBAC) posed certain risks including but not limited to uterine rupture, and that multiparous patients tend to progress through labor faster than those patients who have not given birth before.

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5. On November 23, 2008, at 0004,[2] C.P. presented at the Labor and Delivery Department of La Palma Intercommunity Hospital, where Respondent had privileges. At that time, C.P. was at 37 weeks, 3 days gestation. She complained of contractions and abdominal cramping which she rated as 5 on a scale of 1 to 10. She was received by the charge nurse on the floor at the time, Francisca Bautista, who took a medical history which included C.P.'s previous births, her pain level, and the patient's statement that she had been experiencing contractions every five minutes since 2130 the night before. Nurse Bautista placed an external fetal monitor and then assessed the patient finding that the cervix was dilated to one centimeter and was 80 percent effaced. The fetal head was at minus 2 station, and the fetal heart tracing was reassuring.

6. At 0045, Nurse Bautista telephoned Respondent and reported her assessment. Respondent gave orders to admit the patient and prepare her for a cesarean section later that morning. He did not find any indication of urgency in Nurse Bautista's report, and he considered it wiser to wait until the day shift came on at 0700 so that additional personnel would be available rather than stretch the limited night shift staff on duty at that time. His admission orders included continuous external fetal monitoring, placement of an intravenous line, no food or beverage, intravenous ampicillin every four hours, Stadol for pain, and Phenergan for nausea, as needed. He instructed Nurse Bautista not to give the patient Terbutaline.[3] Nurse Bautista read back Respondent's orders, which Respondent later signed. During that conversation, Respondent did not ask Nurse Bautista if C.P. was experiencing pain. At 0050, C.P. signed a consent form for a repeat cesarean section.

7. Respondent vehemently denies Nurse Bautista telling him that C.P. was in pain. He asserts she told him only that she had cramps of 5 on a scale of 1 to 10. His testimony in that regard was not credible for the following reasons: (1) Nurse Bautista filled out an Admission/Observation Assessment which she signed at 0030. That assessment indicates that the patient was in pain that was rated as 5 on a 1-10 scale. The assessment sheet also indicates that Respondent was notified at 0045. (Exhibit 10, page 865.) (2) Respondent ordered Stadol, a narcotic analgesic for C.P. (3) Respondent claimed he never ordered Stadol for pain and that he signed the order only because he already planned to resign from the hospital, and leaving the order unsigned would result in administrative difficulties within the hospital which he hoped to avoid. That testimony was also not credible in light of the fact that Nurse Bautista read back Respondent's orders to him. Thus, he had the opportunity to correct, modify or change any portion of the orders but chose not to do so.

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[2] All time references herein are to the 24-hour clock.

[3] Terbutaline relaxes the uterus causing a decrease or cessation of uterine contractions.

8. Respondent also asserts that he would have gone to the hospital immediately had he been aware that the fetal heart tracings showed variable decelerations. However, the presence of variable decelerations was not established by the evidence. The only evidence of a deceleration was the one reference below.

9. At 0053, Nurse Bautista assigned C.P.'s care to Nurse Catherine Aquino.[4] She took report from Nurse Bautista and then assumed C.P.'s care. At that time, C.P.'s contractions were still five minutes apart, and her pain was still 5 on a 1-10 scale. The cervix was dilated to 2 cm. The fetal heart rate was normal at a baseline of approximately 150 beats per minute. C.P. did not speak English, but her husband did. They communicated to Nurse Aquino that C.P. was there for a vaginal delivery. Nurse Aquino explained to them that VBAC's were not performed at that hospital. That information was inaccurate. Nonetheless, C.P. decided to undergo a repeat cesarean section rather than travel to another hospital for a VBAC. Nurse Aquino complied with Respondent's orders to prepare the patient for a repeat cesarean section by placing an IV line and starting IV fluid, preparing the patient's abdomen, placing a Foley catheter, and continuing to monitor the fetal heart rate.

10. At 0118, the fetal heart rate tracing showed a significant deceleration that lasted two to three minutes. At its lowest point, the fetal heart rate decreased to 90 beats per minute. Nurses Aquino and Bautista placed the patient in the left lateral position, increased her hydration, and gave her oxygen. At the end of the two to three-minute period, the fetal heart rate returned to baseline. Nurse Aquino documented the deceleration and, at 0124, telephoned Respondent to report that development. Respondent was satisfied that the fetal heart rate had returned to baseline. He told Nurse Aquino he would call her at 0700 to schedule the cesarean section, and told her to give C.P. Stadol if she experienced pain and let her sleep. During that conversation, Respondent did not ask Nurse Aquino whether the patient was experiencing pain and, if so, the level of pain she was experiencing.

11. Nurse Aquino was concerned about Respondent's reaction to the deceleration. She was aware that C.P. had undergone a previous cesarean section, and that the prolonged deceleration could be a danger sign possibly indicative of a uterine rupture. She discussed it with the nursing supervisor who told her to call Respondent again if any further developments occurred.

12. At approximately 0140, C.P. complained of pain which she again rated as a 5 on a 1-10 scale. In accordance with Respondent's order, Nurse Aquino gave her Stadol and Phenergan. The fetal heart rate remained near the baseline of 150 with good long term variability and no decelerations upon C.P. taking the medication.

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[4] In 1998, Catherine Aquino earned a medical doctorate in the Philippines. She practiced obstetrics and gynecology in the Philippines from 1994 to 2002, at which time she returned to school and earned a Bachelor of Science degree in nursing. Upon immigrating to the United States, she earned a Master of Science degree in nursing and, in April 2009, she became board-certified as a family nurse practitioner.

13. At 0341, C.P. felt the urge to urinate and wanted to use the restroom. Because she already had a Foley catheter in place, Nurse Aquino thought it best to check the cervix. Upon examination, she found the cervix dilated to 3-4 cm and 90 percent effaced, and the fetal head at the minus 1 station.

14. Nurse Aquino telephoned Respondent again at 0347 to inform him of the changes. Respondent again told Nurse Aquino he would call at 0700 to schedule the repeat cesarean section. He did not say he was coming to the hospital at that time. Respondent did not question Nurse Aquino concerning whether C.P. was in pain or the degree of her pain, and he did not inquire about the fetal heart tracing. Nurse Aquino was surprised that Respondent did not come to the hospital then to perform a cesarean section, and she informed Nurse Bautista of it because, as charge nurse, Nurse Bautista had to be kept informed of all obstetrical patients' progress.

15. At 0431, C.P.'s mother informed Nurse Aquino that C.P.'s water bag had ruptured. Nurse Aquino confirmed the ruptured membrane and found the cervix dilated to 5 cm and 90 percent effaced with the fetal head at the minus 1 station. Contractions were occurring every 3-5 minutes. The pain level remained at 5 on a 1-10 scale.

16. At 0434, Nurse Aquino again telephoned Respondent. She informed him of the new developments and told him to come to the hospital then because the patient was progressing. Respondent did not question Nurse Aquino about the patient's pain or the fetal heart tracing. However, he said he would come to the hospital, and he instructed Nurse Aquino to obtain the patient's consent for a VBAC in case the patient became completely dilated before he could get there. Respondent resided in West Los Angeles at that time, a significant distance from La Palma. He instructed Nurse Aquino to assemble the operating room team, including a surgical assistant. Nurse Aquino informed Respondent (again erroneously) that VBAC's were not performed at La Palma Intercommunity Hospital. Respondent instructed her to obtain the consent anyway. C.P. signed the consent for VBAC at 0500.

17. At no time between C.P.'s presentation and her delivery did Respondent ask Nurse Bautista, Nurse Aquino, or anyone else in the Labor and Delivery Department whether the patient had reported or showed objective signs of pain. At no time before coming to the hospital, did Respondent ask a nurse to send him any part of the fetal heart rate tracing.

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18. Nurse Aquino assembled an operating room team. The anesthesiologist, Emmanuel Addo, M.D., and scrub technician Carmen Fernandez arrived at approximately 0445. Dr. Addo performed a pre-surgical interview with C.P. and prepared his pre-anesthesia evaluation, finding her in active labor and in more pain than usual under such circumstances. He considered the pain possibly due to the previous cesarean section which could have resulted in a uterine tear. Dr. Addo left the bedside and prepared the operating room for an emergency cesarean section by assembling all equipment and medications he believed he would need. He then returned to the patient to ensure she had two IV accesses, and he instructed the nurse to move the patient into the operating room. Although he was ready to begin the anesthesia, Dr. Addo was unable to do so because Respondent had not yet arrived, and the standard of care required him to wait for the obstetrician's arrival before beginning that process.

19. Respondent arrived at the hospital at 0521. The fetal monitor had been removed when the patient was taken to the operating room. Respondent ordered it placed again, examined the tracings which showed the fetal heart rate at the baseline of approximately 150 beats per minute with variability and no decelerations. He assessed the patient and found the cervix dilated to 10 with 100 percent effacement and the fetal head at zero station. In his direct testimony (Exhibit A), Respondent claimed that C.P "had no complaint of or appeared in any distress or pain . . ." However, he did not indicate whether he asked C.P if she was in pain. Since his finding was made approximately 45 minutes after Dr. Addo found the patient in more pain than usual, and since no pain medication or anesthesia had been given during that time, it would be reasonable to surmise that, if anything, C.P. would be in more pain at the time Respondent saw her than she was during Dr. Addo's pre-surgical interview. Accordingly, Respondent's testimony in that regard was not credible.

20. Respondent decided to postpone the cesarean section until the surgical assistant Helene Saad, M.D. arrived. In the interim, he held a "time-out verification" with the rest of the team so that everyone on the team understood what they intended to do and to verify the patient's identification and her consent to the procedure. Respondent did not do anything else to be ready to proceed as soon as Dr. Saad arrived such as scrub, place the patient in the correct position, put the table at a left tilt, ensure the placement of the Foley catheter and blood pressure cuff, ensure that the nurse was prepared to sterilize the abdomen, give the patient an antacid in case she had to be placed under general anesthesia, and ensure that the neonatal preparations had been made and that neonatal staff was ready to receive the baby.

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21. Dr. Saad arrived at 0533.[5] She and Respondent scrubbed together, Dr. Addo performed a spinal block and adjusted the tilt of the table. He also gave the patient oxygen because he was concerned that the fetus could have been compromised by the length of the labor. Nurse Aquino sterilized the abdomen with betadine, and the patient was properly draped. Respondent then proceeded with the cesarean section at 0545.

22. Respondent found extensive adhesions between the uterus and bladder and between the uterus and the pelvic sidewalls. He was required to take additional time to lyse the adhesions before he could proceed with the delivery. Once he began the delivery process, he found the baby's head to be wedged in the pelvic vault.

23. At 0601, Respondent asked Nurse Aquino, who was the circulating nurse for the procedure, to put on a sterile glove, place her hand into the vagina, and push on the baby's head. Nurse Aquino attempted to do so but felt only Respondent's hand. She was unable to locate the baby's head with her hand. At 0603, Respondent called for a vacuum assist, but that attempt was unsuccessful. However, a subsequent vacuum assist was successful, and a baby girl was delivered by cesarean section at 0608.

24. Upon delivery, the baby was blue, flaccid, and showed no signs of life. Apgar scores were zero at one minute. Extensive attempts at resuscitation by the neonatal nurse and Dr. Addo, which included positive pressure ventilation with oxygen, chest compressions, warmth, drying, placement of an endotracheal tube, and epinephrine, were unsuccessful. At 0630, Dr. Addo pronounced the baby dead.

25. During the procedure, Dr. Addo noticed a light green fluid in the field. He could not determine whether it was meconium. Hospital records indicate the amniotic fluid was clear, consistent with an absence of meconium.

26. C.P. suffered a number of uterine tears during the delivery. Respondent repaired them after the baby was delivered. During that part of the procedure, C.P. became increasingly restless on the table until, at approximately 0700, Dr. Addo administered general anesthesia and C.P. fell asleep. Surgery ended at approximately 0840.

27. Post-operatively, C.P.'s experienced an increased heart rate and decreased blood pressure. Dr. Addo placed a central IV line and ordered a transfusion of two units of blood. C.P. was transferred to the intensive care unit where she required an additional two units of blood the following morning. The remainder of her hospital stay was unremarkable.

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[5] When Nurse Aquino called, Dr. Saad initially declined to assist because she was suffering from a severe headache. She later called back and told Nurse Aquino she would come in to assist anyway. Dr. Saad arrived at the hospital within 30 minutes thereafter. Her being the final team member to arrive was due to the time that lapsed between her initial declination and her subsequent acceptance of the assignment.

28. An autopsy on the baby was performed on November 28, 2008. Abundant meconium was found on the anus and in the alveolar spaces of the lungs, and a material described in the autopsy report as "abundant thick mucus" of a "slightly cloudy gray-greenish appearance" in the proximal trachea and throughout the bronchial airways was also found. The lungs were not aerated. The pathologist found that the infant had suffered severe meconium aspiration at the time of delivery with obstruction of the proximal airways and distal trachea. There were also small petechiae (blood spots) on the pleural surfaces.

29. In closing argument (Exhibit H), Respondent made the following assertions:

a. Nurse Bautista intentionally misled Respondent with respect to C.P. so that he would not ask for a cesarean section.

b. Because the nurses allowed C.P. to remain in pain and with contractions, and because they gave her pain medication, the nurses "allowed VBAC against their own common understanding of the practice of the hospital." (Exhibit H.)

c. The hospital staff interfered with Respondent's knowledge and treatment of the patient at the time of admission.

d. Respondent claims that "interference from the nursing staff and the fact that [he] was kept in the dark about [his] patient's condition prevented [him] to take necessary steps on time."

30. None of Respondent's claims referenced above were supported by the evidence.

31. Respondent also claimed that many of the medical records were falsified by various hospital personnel. He failed to establish the truth of that allegation.

32. Respondent attributes blame to several individuals and, to a certain extent, hospital policy, for the occurrences of November 23, 2008. He does not acknowledge any wrongdoing on his part or responsibility for his own actions and inactions. Accordingly, Respondent demonstrated neither remorse nor regret at the hearing.

*The Experts*

33. Each party offered the reports and testimony of two expert witnesses. All four witnesses were highly qualified to offer expert opinions in their respective fields.

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*Jessica Kingston, M.D.*

34. Jessica Kingston, M.D. reviewed the medical records and several deposition transcripts relating to a civil lawsuit brought by C.P. Dr. Kingston wrote a report and provided expert witness testimony for Complainant. Her testimony was both credible and persuasive. She correctly defined the standard of care.

35. Dr. Kingston found that Respondent had committed an extreme departure from the standard of care in delaying the start of C.P.'s cesarean section. In her report (Exhibit 14), Dr. Kingston wrote:

> Based on the patient's presenting complaints, clinical course and physical examinations, she was in early labor by 1:43 am when she required analgesia for her painful contractions. Physical exam done at 3:41 am further supported that she was in labor based on her cervical change. Multiparous patients, such as [C.P.], are expected to dilate at least 1.2 cm per hour when in active labor. Both Dr. Abrahams and [C.P.] stated that based on discussions they had had during the course of her prenatal care that the plan was for delivery by repeat cesarean section. If Dr. Abrahams planned to deliver [C.P.'s] baby by repeat cesarean section and not by VBAC, then the goal would be to perform the surgery in early labor to minimize any risks associated with trial of labor. In his interview with the Medical Board, Dr. Abrahams did state that he told the nurse that he was coming in to evaluate the patient when he was on the phone with her at 3:47 am, yet he did not arrive for over an hour and a half until 5:21 am. He gave no explanation or justification for this delay in his deposition or in his interview with the Medical Board.
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> The only acceptable reasons to delay the start of repeat cesarean section in this scenario would be if the appropriate personnel necessary for the surgery were not available or if the patient had a more urgent medical need than delivery. Dr. Abrahams did not instruct the nurse to call for the OR team until 4:34 am, and when the OR team was notified; they were all present and ready to begin surgery in less than an hour. Therefore, not only did Dr. Abrahams unnecessarily delay his decision to go to the hospital to perform [C.P.'s] cesarean, but also once he arrived at the hospital, there was an additional delay of 24 minutes before he started operating. He claimed he was waiting for Dr. Saad to start the surgery, but knew that she would arrive shortly and did have the scrub tech, Ms. Hernandez, ready to start the surgery with him. [C.P.] was arguably in labor as early as 1:43 am, and indisputably in labor by 3:41 am when she was 3-4 cm dilated.

> Dr. Abrahams should have gone to the hospital when notified by the nurse at 3:47 am, and if he had, could have started the cesarean over an hour earlier.
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> In addition, Dr. Abrahams should have been aware of the hospital policy on VBAC. By not going to evaluate his patient personally, he was passively allowing a trial of labor. If he was going to do this, then hospital policy required him to be physically present in the hospital for his patient's entire labor, and also to have an anesthesiologist and pediatrician in house as well.

(*Id.* at pages 6-7.)

36. Dr. Kingston found that Respondent committed a simple departure from the standard of care by failing to personally assess C.P. and the fetal heart tracing after the deceleration at 0118. Dr. Kingston wrote in her report:

> A major risk of trial of labor is of uterine scar dehiscence, or uterine rupture, which can be life threatening for the mother and/or the baby. Signs that the scar is separating include fetal heart rate decelerations, loss of fetal station on exam and persistent maternal pain out of proportion to that expected with labor. When he spoke with the nurse at 3:41 am and 4:34 am, there is no documentation that supports that he asked for specific details about the fetal heart tracing. In fact, on review of the fetal heart tracing, it shows that there were no accelerations from approximately 2:00 am until about 5:30 am when there was a single 10 beat acceleration. Furthermore, the variability in the fetal heart tracing was minimal over this time period as well, and thus fetal status was in question. Dr. Abrahams stated in his interview with the Medical Board that he was not notified of any concerns with the fetal heart tracing and did not review the fetal heart tracing during his interview. He also stated that he did not review any of the fetal heart tracing except the brief monitoring that was done in the operating room just before delivery.

(*Id.* at pages 7-8.)

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37. Dr. Kingston also found that Respondent had committed an extreme departure from the standard of care "in Dr. Abrahams' failure to perform [C.P.'s] cesarean section prior to the second stage of labor. This failure contributed to maternal morbidity and need for blood transfusion and ICU level of care postoperatively and may have also contributed to the cause of fetal death." In her report, Dr. Kingston wrote:

> Dr. Abrahams and [C.P.] discussed delivery planning over the course of her prenatal care. Based on [C.P.'s] deposition, she stated that she agreed to undergo cesarean section because Dr. Abrahams felt that labor was too risky and dangerous for her. Documentation of these discussions is not in [C.P.'s] prenatal chart, but both she and Dr. Abrahams agreed that this was the plan. [¶] . . . [¶]
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> Because Dr. Abrahams provided prenatal care for her, it was his responsibility to provide emergency care for her either personally or with a designated covering physician. He accepted the call when Nurse Bautista notified him of [C.P.'s] status and proceeded to give orders. Based on this, he assumed care and responsibility for her and her baby. Regardless of where he expected her to go for emergency care or delivery, he accepted her as a patient and was thus obligated to care for her. If he was not physically able to go to the hospital to assess her at that time, then he was obligated to make arrangements for a covering physician to assume that role.
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> There was a significant, unacceptable delay from the time [C.P.] was noted to be in labor until the time the cesarean was performed. Over this time period her labor progressed and the fetal head descended in her pelvis. When a cesarean section is performed in the second stage of labor (cervix fully dilated), extraction of the baby from the uterus and pelvis can be more difficult. If Dr. Abrahams had performed [C.P.'s] cesarean prior to the second stage of labor, the fetal head would not have been as low in the pelvis, and delivery would have likely been easier. In addition, trauma to [C.P.'s] uterus with delivery would have likely been less, and she probably would not have lost as much blood. The risk of uterine lacerations and extensions of the uterine incision are much greater when cesarean is performed in the second stage of labor. It can happen during cesarean sections for other indications, but is much less common.

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> I suspect that the time from uterine incision to delivery of the baby would have been considerably less than what it ultimately was if Dr. Abrahams had performed [C.P.'s] cesarean section sooner. The time of uterine incision is not clearly documented in the medical records, but it was 23 minutes from the time of the skin incision to the time of the baby's delivery. Nurse Aquino documented that she assisted Dr. Abrahams by inserting her hand vaginally to elevate the fetal head at 6:01 am, and this was 7 minutes before the baby was out. While it can take more time from skin incision to delivery for a repeat cesarean because of scarring, typically it does not take more time to deliver the baby once the uterine incision has been made compared to that of a primary cesarean section where no scar tissue is present. Dr. Abrahams had already been making attempts to deliver the baby before nurse Aquino assisted, so it was longer than 7 minutes from the time he made the incision on the uterus to the time the baby was delivered. On average, the time from uterine incision to delivery of the baby is 2 minutes or less. In [C.P.'s] cesarean section it took 4-5 time longer.

(*Id.* at pages 9-10.)

38. Dr. Kingston also opined that the standard of care requires that a physician question a nurse and ask for clarification or qualification if the nurse omits information or is confusing in relaying it to the physician. Specifically, the standard of care requires an obstetrician to ask a nurse about the patient's level of pain and about the fetal heart tracings if that information is not readily forthcoming.

39. As indicated above, Dr. Kingston credibly opined that, in this case, the patient was in labor at 0143, when she required Stadol for painful contractions, and was indisputably in labor at 0341 when she felt the urge to urinate, the cervix was dilated to 3-4 cm and was 90 percent effaced. Yet, Respondent chose to wait until 0700 to schedule the repeat cesarean section not realizing the urgency of the situation. His failure to recognize C.P.'s progressing labor and to come to the hospital and perform the cesarean section in a timely manner constituted an extreme departure from the standard of care.

*Michael Friedman, M.D.*

40. Michael Friedman, M.D. also reviewed the records and depositions, wrote a report, and provided expert witness testimony for Complainant. Dr. Friedman found that Respondent committed a simple departure from the standard of care in failing to respond appropriately to the nurses' calls and come to the hospital in a timely manner, and a simple departure from the standard of care with respect to Respondent's actions after he reached the hospital. Dr. Friedman opined that Respondent committed extreme departures from the standard of care by causing the death of C.P.'s baby and by failing to perform a cesarean section shortly after C.P.'s hospital admission.

41. However, at the hearing, Dr. Friedman gave incorrect definitions of simple and extreme departures from the standard of care. Accordingly, his opinions can be given little weight.

*Juan Vargas, M.D.*

42. Juan Vargas, M.D. reviewed records, wrote a report, and provided expert witness testimony for Respondent. Dr. Vargas found no departures from the standard of care with respect to Respondent's approach to management of the patient, the timing of his decision to go to the hospital, his instruction to assemble the operating room team, and his decision to wait for Dr. Saad to arrive before commencing the cesarean section, Yet, despite those opinions and Respondent's testimony that there can be no labor without pain, Dr. Vargas testified that it is a patient's contractions that drive the labor since medications can affect the pain level, and that Respondent should have taken into account the possibility of adhesions that could delay the delivery. Further, in his report (Exhibit E), Dr. Vargas opined: "It is likely that the infant's condition at birth was the result of the difficulties encountered during the abdominal delivery of the fetal head and the delivery of the infant. This can be a tremendously challenging situation even for the most experienced of obstetrician[s]." However, Dr. Vargas did not follow up on that opinion by addressing the obvious question of whether, how, and to what extent, the delay in commencing the cesarean section affected the position of the fetal head at the time of delivery.

43. Unlike Complainant's experts who reviewed all of the medical records and the deposition transcripts from the civil action brought by C.P., Dr. Vargas reviewed only the medical records. In addition, Dr. Vargas was not asked to define the standard of care or simple and extreme departures from the standard of care. Further, in his report, Dr. Vargas referred to only two of the telephone calls the nurses made to Respondent, thus creating an incomplete picture of what actually took place on the night in question. Because the deposition transcripts of the physicians and nurses who were on the labor and delivery floor or in the operating room could well contain information that might have been of value to Dr. Vargas in forming his opinions, because it cannot be ascertained whether Dr. Vargas applied the proper standard in evaluating Respondent's actions, and because Dr. Vargas's opinions were based on an incomplete factual basis, his report and testimony are afforded little weight. An "expert opinion is worth no more than the reasons upon which it rests." (Citation.) (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116.)

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*Robert Castro, M.D.*

44. Robert Castro, M.D. is a neonatologist. He made it clear both in his report and in his testimony that his evaluation and opinions related solely to the neonatal aspect of the case, and that he was not offering any opinions concerning whether Respondent deviated from the standard of care.

45. Like Dr. Vargas, Dr. Castro reviewed only medical records relating to C.P.'s labor and delivery. Like Dr. Vargas, Dr. Castro found that umbilical blood gases indicated a respiratory acidosis, but not a metabolic acidosis, and that an infant with those blood gases should have been born with a heartbeat and respiration, or should have responded positively to the team's resuscitative efforts. Further, because the amniotic fluid and the placenta were not meconium stained, he found it puzzling that the pathologist found severe meconium aspiration. Based on the records he reviewed, Dr. Castro opined that the infant's condition at the time of delivery, and her non-responsiveness to the resuscitation measures cannot be adequately explained by the information in the medical records, but that it was "more likely than not" (Dr. Castro's term) that "the infant had a predisposing existing infection and/or other abnormalities accounting for the apparent stillborn death." However, Dr. Castro failed to explain why, if the infant had such a severe infection, that the fetal heart tracings remained reassuring throughout the labor with the exception of the one 2-3 minute deceleration, or why there is no mention of an infection in the autopsy report.

46. Despite his strong qualifications, Dr. Castro's opinions are of little value in this action because Complainant did not allege in the Accusation that Respondent caused the death of C.P.'s child.

*The Letter from Rabbi Shofet*

47. Respondent offered a letter from his Rabbi, David Shofet, who stated that Respondent told him he did not cause the death of the infant, that he was "sad" about the incident, and that he was contesting the Accusation not only to defend his innocence, but also to protect other children from falling victim to the same cause of death. Rabbi Shofet went on to state that Respondent comes from an honorable family, and that he would never hide or distort the truth regarding any loss of life.

## LEGAL CONCLUSIONS

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2234, subdivision (b), for gross negligence, as set forth in Findings 3 through 28, and 34 through 39.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2234, subdivision (c), for repeated negligent acts, as set forth in Findings 3 through 28, and 34 through 39.

3. The law is clear that the standard of proof to be used in this proceeding is "clear and convincing." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.) "Evidence of a charge is clear and convincing so long as there is a 'high probability' that the charge is true. (See, e.g., *In re Angelia P., supra*, 28 Cal.3d at p. 919; BAJI No. 2.62 (8th ed. 1994); 1 Witkin, Cal. Evidence (3d ed. 1986) Burden of Proof and Presumptions, § 160, p. 137.) The evidence need not establish the fact beyond a reasonable doubt." (*Broadman v. Comm'n on Judicial Performance* (1998) 18 Cal.4th 1079, 1090.) Complainant sustained her burden of proof.

4. The purpose of the Medical Practice Act[6] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The purpose of physician discipline is to protect the life, health and welfare of the people at large and to set up a plan so that those who practice medicine will have the qualifications which will prevent as far as possible the evils which result from ignorance or incompetence or a lack of honesty and integrity. The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) " . . . Business and Professions Code section 2234 does not limit gross negligence or unprofessional conduct to the actual treatment of a patient—as opposed to administrative work—and does not require injury or harm to the patient before action may be taken against the physician or surgeon." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1053.)

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[6] Business and Professions Code sections 2000 through 2521.

> 5. The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.)

(*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

6. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

7. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

8. Respondent committed both simple and extreme departures from the standard of care in several ways on November 23, 2008. Paramount among them was his failure to recognize C.P.'s labor and to come to the hospital to perform the cesarean section sooner than he did. Respondent treated C.P. pre-natally. He was aware she was multiparous. He knew the labor of multiparous patients can progress faster than in patients who have not previously given birth. He knew C.P. had undergone a prior cesarean section. He knew a patient with a prior cesarean section can have adhesions that will require lysing, necessitating the expenditure of additional time and delaying the delivery.

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9. C.P. presented to the Labor and Delivery Department at 0017. The baby was delivered at 0608, and surgery was not completed until 0840. When he was first notified of C.P.'s presence in the hospital at 0045, Respondent correctly decided to wait until additional personnel were in the hospital on the day shift before performing the cesarean section, because nothing in Nurse Bautista's report indicated a need to perform the procedure at that time. However, at 0124, when Nurse Aquino telephoned him to inform him of the two to three-minute deceleration, Respondent should have gone to the hospital to assess his patient if he was unable to receive a copy of the fetal heart tracing at his home. C.P. was definitely in labor at 0341 when she felt the urge to urinate, the cervix was dilated to 3-4 cm and was 90 percent effaced. Respondent had the opportunity and the obligation to go to the hospital then and tend to his patient. He failed to do so. At 0434, when he was informed the patient's water bag had ruptured, he told Nurse Aquino he was coming to the hospital, but he did not arrive there until 0521. He then postponed the cesarean section to await Dr. Saad's arrival but did nothing to prepare the team and the room for the procedure so that the cesarean section could commence immediately upon Dr. Saad's arrival.

10. Although Respondent was not criticized for not coming to the hospital at or near the time C.P. presented, it is disingenuous of Respondent to claim he was unaware and was kept unaware that she was in labor. As early as the first report by Nurse Bautista at 0045, Respondent told the staff he would arrange for the cesarean section in the morning, specifically at 0700. If he did not think she was in labor, that arrangement would have been unnecessary. Yet, throughout the night, until 0347, after C.P.'s water bag had ruptured, the cervix was dilated to 5 cm and was 90 percent effaced, and the fetal head was at the minus 1 station, Respondent reiterated his intent to call at 0700 to schedule the cesarean section.

11. Complainant did not have to prove the patient was harmed in order for cause for discipline to exist. (See *Fahmy* and *Kearl*, above.) However, she did so anyway via expert witness testimony that Respondent's dilatory actions resulted in a very difficult delivery with the baby's head wedged in the pelvic vault compromising the baby and making resuscitation more difficult, the baby being stillborn, and Respondent's patient suffering uterine tears requiring surgical repairs, four units of transfused blood, and a stay in the intensive care unit.

12. Respondent refuses to accept any responsibility for the events of November 23, 2008. He blames the nurses, the hospital, and various members of the operating room team for the adverse outcome, claiming they were either incompetent in carrying out their respective duties, or even fraudulent by keeping him uninformed of the patient's pain level and the fetal heart tracings, and going so far as to falsify hospital records to place the blame for the unsuccessful result on him. Respondent failed to establish the truth of any of those allegations.

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13. At the hearing, Respondent even blamed his own deposition, taken in the civil action brought by C.P. He stated the deposition had not been done correctly and that the attorney assigned by his malpractice insurance carrier to represent him had done a poor job. Therefore, Respondent refused to correct or sign the transcript. Respondent's deposition transcript was used extensively at the administrative hearing to impeach his testimony. Respondent objected to its use for that purpose because he disavowed its contents for the above reasons. That argument is rejected. Code of Civil Procedure section 2025.520, subdivision (f) provides: "If the deponent fails or refuses to approve the transcript within the allotted period, the deposition shall be given the same effect as though it had been approved, subject to any changes timely made by the deponent."

14. Respondent is neither regretful nor remorseful for his actions and inactions in connection with the events of November 23, 2008. It is well-established that a respondent convinced of his innocence is not required to demonstrate artificial acts of contrition. (*Calaway v. State Bar* (1986) 41 Cal.3d 743, 747-748; *Hall v. Committee of Bar Examiners* (1979) 25 Cal.3d 730, 744-745.) However, it is also well-established that remorse for one's conduct and the acceptance of responsibility are the cornerstones of rehabilitation. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) Mere remorse does not demonstrate rehabilitation. A truer indication of rehabilitation is sustained conduct over an extended period of time. (*In re Menna* (1995) 11 Cal.4th 975, 991.) The evidentiary significance of misconduct is greatly diminished by the passage of time and by the absence of similar, more recent misconduct. (*Kwasnik v. State Bar* (1990) 50 Cal.3d 1061, 1070.)

15. Regardless of whether Respondent is remorseful for his negligence, it is difficult to determine the level of his rehabilitation because his practice is in-office only, and he does not have privileges to deliver babies at any hospital.

16. Despite a tragic outcome, Respondent's discipline is based on a single patient for whom he provided care and treatment approximately seven years ago. He is criticized not for his surgical skill, but for his medical judgment. Respondent has no prior history of discipline. These factors, taken collectively, indicate that outright revocation of Respondent's certificate would be overly harsh and punitive. Instead, Respondent will be placed on probation with terms and conditions designed to protect the public health, safety, welfare and interest. The terms of probation will include a period of suspension to give Respondent the opportunity to contemplate the role he plays as an obstetrical team member, and his responsibilities to his patients to ensure he has the necessary information to make medical decisions in their best interests whether that information is volunteered by a team member or specifically requested by Respondent.

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## ORDER

Certificate No. G 86496 issued to Respondent, Ariel Eliahou Abrahams, M.D., is revoked pursuant to Legal Conclusions 1 through 15, separately and for all of them. However, the revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions.

### 1. Actual Suspension

As part of probation, Respondent is suspended from the practice of medicine for 120 days beginning the 16th day after the effective date of this Decision.

### 2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

### 3. Clinical Training Program

Within 60 calendar days of the termination of suspension, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine (program). Respondent shall successfully complete the program not later than six months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program has been completed. If Respondent did not successfully complete the clinical training program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after Respondent successfully completes the clinical training program, Respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

**4. Practice Monitoring**

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the termination of suspension, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days. After being so notified, Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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5. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

6. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

## 9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

## 10. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

## 11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

## 12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

## 13. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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## 14. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

## 15. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

## 16. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

Dated: November 10, 2015

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H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings